STATEMENT BY

LIEUTENANT GENERAL KEVIN C. KILEY M.D.
THE SURGEON GENERAL OF THE UNITED STATES ARMY

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Thank you for inviting me here today to discuss the medical holdover (MHO) program and for allowing me the opportunity to tell you about the extraordinary efforts of our Army Medical Department (AMEDD) team as they work with our partners represented here. Let me begin by describing the magnitude of the effort. Eight percent of the mobilized force eventually enters MHO. About 2 percent come in during pre-deployment training, another 3-4 percent as medical evacuations from the theater of operations, and another 2-3 percent upon redeployment. That translates into approximately 1,000 new MHO patients every month. We finalize and out process about the same number each month. Since November 1, 2003 we have processed nearly 16,000 MHO patients through the MHO system. Of those, nearly 10,000 were successfully returned to their units, fit to re-mobilize. We performed Medical Evaluation Boards (MEB) on the remainder, and assisted them through the Physical Disability Evaluation System (PDES). More than 90 percent of those Soldiers were either medically separated or medically retired from military service.

Sixteen thousand patients is a large number of patients. However, that number alone does not fully describe the level or complexity of effort necessary to care for these Soldiers. Consider for a moment that the average Soldier uses our medical treatment facilities about four times a year. The average MHO patient uses our services four times a month, and is with us between five and seven months. That culminates in a tremendous amount of health care being delivered at our camps, posts, stations, and now at the Community Based Health Care Organizations (CBHCO).

The CBHCOs actually belong to Forces Command, but since the AMEDD provides quality oversight for their medical operations, I'll say a word about them. The true measure of their success will be their ability to heal Soldiers, and either

return them to their units or assist them through the PDES. Thus far, the CBHCOs are receiving high marks from our patients because the CBHCOs allow Soldiers to live at home while receiving care. One of the other, more tangible benefits of the CBHCOs is that they allow us to better leverage the capabilities of the TRICARE Network, Veteran's Affairs health care facilities, and Navy and Air Force military treatment facilities (MTFs). For instance, CBHCO patients who live in the catchment areas of Navy and Air Force MTFs are enrolled to those MTFs.

As Mr. Denning indicated, we had problems in the MHO arena in the October / November 2003 time frame. I would like to spend just a moment letting you know how far we have come since then.

One of our first improvements was the 25-day rule. That tool allows us to screen mobilized Soldiers, and send home those who have pre-existing conditions that make them non-deployable. Since November 1, 2003 we have successfully screened and sent home 8,758 non-deployable RC Soldiers. That's 8,758 people who would have otherwise been MHO patients.

For those who do become MHO patients at our MTFs, we have enhanced access standards: 72 hours for specialty referrals, one week for magnetic resonance imaging (MRI) and other diagnostic studies, and surgery within two weeks of the time the doctor says the patient is ready. I am pleased to report that our health care professionals meet those standards 89% of the time.

Enhanced access standards are a success story and one with a surprising lesson learned. In our efforts to put MHO patients at the front of the line, we asked Soldiers "Are you Guard or Reserve?" For some of them, that question made them think "Why are they asking? Isn't it all One Army? Aren't we all active duty once we're mobilized?" And quite frankly, some of them were more than offended; they were suspicious of our motives. The lesson was that we should not ask the question "Are you Guard or Reserve?" Now we look at the patients' records to determine if they are Guard or Reserve.

Even before we had the CBHCOs, we recognized that we could – and should - allow some of our MHO patients to live at home simply because they lived near one of our installations. In conjunction with our partners at the Installation Management Activity (IMA) and their garrison commanders, we instituted a policy to move patients from their mobilization stations to the installations and MTFs closest to their homes whenever possible. Today, in addition to the CBHCOs, we have 278 patients who are obtaining care at MTFs near their homes, living with their families and sleeping in their own beds at night.

In December 2003 we asked our manpower experts at the Medical Command (MEDCOM) to tell us how many people we needed to clinically manage the MHO patients. Their analysis told us we needed 967 doctors, nurses, technicians, and other staff to provide the dedicated level of care necessary for this population. Due to shortages of qualified people in some areas of the country, not all of these positions are filled. However, between mobilizations, hiring actions, and contracts, we have professionals in 772 of those positions dedicated solely to the MHO effort.

As I alluded earlier, most MHO Soldiers heal and are able to return to their units. Nearly 36 percent, however, require a Medical Evaluation Board. In that process, our physicians make a simple determination: does the Soldier meet retention standards? If not, the Soldier is referred to a Physical Evaluation Board (PEB), operated by the Physical Disability Agency (PDA) under the auspices of the Army Deputy Chief of Staff for Personnel (G1). They determine if the Soldier is fit for further service, and if not fit, they determine the Soldier's level of disability. Our collective staffs work continually to make the transition from MEB to PEB seamless and efficient.

I know the Committee is interested in how we track Soldiers through MHO. Since the inception of MHO, we have used the Medical Operational Data System (MODS) to track where our patients are physically located, as well as their medical progress. All of our partners in the MHO program recently agreed to use MODS as the one overarching source of data and reports on MHO patients. To

that end, we have already tied in the tracking systems used by Human Resources Command, Defense Finance and Accounting Service, the Physical Disability Agency and others so that the various systems automatically update each other. That work is ongoing as we continue to identify data sources and systems necessary to the clinical and administrative management of these patients.

These are just some of the improvements we have made in the MHO process. My colleagues on the panel will discuss even more. Let me close with two points. First, MHO is a good news story. We in the AMEDD have provided an enormous amount of world class health care to the MHO Soldiers, and have assisted Forces Command in the establishment of the CBHCOs so that as many MHO Soldiers as possible can receive care at home. Second, the AMEDD, like the rest of the Army and the rest of the Nation, recognize the patriotism and vital importance of our Guard and Reserve Soldiers. We truly are One Army, and we are proud to care for our patients.